Section II

IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES

FY 2005 State Plan
Children, Youth and Families

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The State's "Revised statutes of Missouri 2000" 630.020 set Departmental goals and duties. It says; "1. The Department shall seek to do the following for the citizens of this state:
(1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention;
(2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible;
(3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities or alcohol or drug abuse.
2. The department shall make necessary orders, policies and procedures for the government, administration, discipline and management of its facilities, programs and operations".

The above Missouri Statute provides for the establishment and implementation of rules for community based programming and an integrated system of care for individuals with mental illness. Services available to children, youth and families in Missouri are:

- **Community Psychiatric Rehabilitation** – Provides a range of essential mental health service to children and youth with serious emotional disturbances. These community-based services are designed to maximize independent functioning and promote recovery and self-determination. In addition, they are designed to increase the interagency coordination and collaboration in all aspects of the treatment planning process. Ultimately, the services help to reduce inpatient hospitalizations and out-of-home placements. Community Support Work is the heart of CPR programming. Individuals access medical and dental care along with other critical services with the assistance of their community support worker. The worker is often the person coordinating services and finding resources needed to pay for critical medical, dental or other related services. In January 2002, The Division of Comprehensive Psychiatric Services added an "intensive" level of care to the Community Psychiatric Rehabilitation (CPR) program and implemented a Provisional Admission category in CPR. These two changes allow expanded services under the CPR program service umbrella. Children and youth are able stay in the community when they experience an acute psychiatric condition and need time limited intensive services through the CPR program. The Provisional Admission allows 90 days for providers to enroll a child or youth who meets the disability, but not the diagnostic requirements so that a comprehensive evaluation may be completed. If the agency determines that an eligible diagnosis cannot be verified then there is time to transition the individual to appropriate programs and services. In March of 2003 CPR eligibility codes for children and youth were expanded with three new diagnoses. They are: Major depressive

disorder, single episode; Bipolar disorder, not otherwise specified; Reactive attachment disorder of infancy or early childhood.

- **Intensive Targeted Case Management (ITCM)** – Children already admitted to the system are eligible for ITCM. The service supports children and families by linking them to the service system and coordinating the various services they receive. Case managers work with the families, treatment providers and other child-serving agencies to assist the children to remain in or progress toward least-restrictive environments.
- **Day Treatment** offers an alternative form of care to children with SED who require a level of care greater than can be provided by the school or family, but not as intensive as full-time inpatient service. Day treatment may include vocational education, rehabilitation services, individual and group therapies and educational service.
- **Missouri Juvenile Justice Information System (MOJJIS)** is the response to statute which intends to have the divisions of circuit courts and the departments of social services, mental health elementary and secondary education and health share information regarding individual children who have come into contact with or been provided service by, the courts and cited departments. The Department of Mental Health participates in this effort while maintaining compliance with HIPAA and AOD Confidentiality Laws.
- **Juvenile Justice Advisory Group (JJAG)** provides leadership and education to the people of Missouri in the area of juvenile justice and ensures the safety and well being of all youth, their families and community. JJAG serves as the conduit for federal, state and local education, treatment and prevention services. This group advises the Governor and the Department of Public Safety, which maintains compliance with the Juvenile Justice and Delinquency Prevention Act of 1974.
- **Missouri Alliance for Youth** is a partnership between the Department of Mental Health and Juvenile Justice. Comprised of multiple stakeholders, the focus is to improve knowledge of and services for youth with mental health needs involved in the juvenile justice system. This partnership introduced the MO MAYSI project, a mental health screening tool for the juvenile justice system. It collects statewide data on mental health indicators for youth through all stages of the juvenile justice system. Additionally, the Alliance supports seven demonstration projects across the state which partner local juvenile offices with community mental health centers to develop and evaluate services for youth with mental health needs at risk of or currently involved in the juvenile justice system.
- **Residential Treatment -** These services consist of highly structured care and treatment to youth on a time-limited basis, until they can be stabilized and receive care in a less-restrictive environment or at home.
- **Treatment Family Homes -** This service provides individualized treatment within a community-based family environment with specially trained foster parents. It allows out-of-home services for those children who need them. Children are able to remain in their own community and often in their home school districts.
- **Respite -** Temporary care given to an individual by specialized, trained providers for the purpose of providing a period of relief to the primary care givers.

- **Family Support -** A treatment plan driven service that is designed to develop a support system for parents of children with a serious emotional disturbance and/or acute crisis. This service provides parent-to-parent guidance that is directed and authorized by the treatment plan. Some of the activities provided in this service are: problem solving, emotional support, disseminating information, and linking to services.

The Department of Elementary and Secondary Education (DESE) and its Division of Special Education is the State's lead agency on the **Individuals with Disabilities Education Act (IDEA)**. The Division of Special Education is funded primarily through the Federal Government and implements programs that support IDEA. A comprehensive system of personnel development has been developed and implemented which is coordinated, as appropriate, with each district's Professional Development Committee and Comprehensive School Improvement Plan and includes a needs assessment and description of the activities established to meet the identified needs in the areas of: a) number of qualified personnel available to serve all students with disabilities; b) appropriate in-service training of staff; c) required training for paraprofessionals; d) dissemination of relevant research, instructional strategies, and adoption of effective practices.

Furthermore, in 2000 the Missouri Department of Mental Health (DMH), Division of Comprehensive Psychiatric Services (CPS) and the Curators of the University of Missouri – Columbia (University) entered into a unique contract. The contract has been continually renewed each year since 2000 and remains a viable and notable collaboration, the Center for the Advancement of Mental Health Practice in Schools (the Center). The Center is a partnership between the College of Education of the University and the DMH intended to:

- Assure that University trained teachers and school administrators are well grounded in the principles of, and effective approaches to: (1) mental health promotion, (2) early identification and intervention in public mental health problems, and (3) collaboration with the public mental health system in serving children and youth with serious emotional disorders and their families.
- Prepare school-based mental health practitioners with training to offer families, children and youth mental health services and supports within the school environment; and
- Promote the development of best practices in public mental health promotion and prevention, early identification and intervention, and treatment services and supports in the school setting

In 2003-2004, the Center completed a number of significant accomplishments:

- The Center has continued to educate school based personnel through an online graduate degree program with a focus in mental health. Students can progress toward either a Master's degree or a post Master's Educational Specialist degree. To date, there are 21 graduate students, (14 Masters and 7

Educational Specialists) enrolled in the formal degree programs from around the State of Missouri, the United States and overseas. As well, there are 20 additional degree seeking students (11 Masters and 9 Educational Specialists) who are in various stages of the degree application process.

- Center staff developed a number of specific academic content modules which represent knowledge/competency-based needs designed to directly assist individuals on their job. The Center is currently developing and translating these modules into sanctioned online coursework also available for student continuing education credit.
- Staff from the Center delivered a number of scholarly presentations at the National Advancing School-Based Mental Health conference on activities and issues impacting state, national and global mental health school issues.
- Six Center proposals were accepted for representation at the Ninth Annual National Conference on Advancing School-Based Mental Health Programs, scheduled fall 2004 in Dallas, Texas.
- The Center director participated in delivering information at Missouri statewide seminars to the Division of Vocational Rehabilitation on Specific Learning Disabilities and Mental Health Correlates.
- Center staff conducted various local workshops on topics such as bullying, teacher stress and burnout, and the mental health implications of eating disorders.
- The Center submitted five publications to contribute to the professional knowledge base as it relates to evidence-based mental health practices.
- The Center actively participated in a National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Directors of Special Education (NASDSE) grant funded project entitled, *MENTAL HEALTH, SCHOOLS, AND FAMILIES WORKING TOGETHER TOWARD A SHARED AGENDA IN MISSOURI.*
- The Center's responsibilities included assisting in the design of the project, conducting the state-wide focus groups, analyzing response data from parents, mental health providers and local educators, as well producing the Executive Summary report of findings.

In other educationally related collaborations, the Missouri DESE and DMH combined efforts to apply for a Shared Agenda grant sponsored jointly by the (NASDSE), Policy Maker Partnership (PMP) and (NASMHPD). Fortunately, Missouri received one of the awards. Missouri became one of only six states in the nation to receive this particular grant, the Shared Agenda Seed Grant. NASMHPS/PMP awarded $10,000 for a children's mental health planning grant to enhance the state's ability to build collaboration across mental health, education and family serving organizations in developing a Shared Agenda. The awarded funds are to support activities that engage stakeholders in dialogue, strategic thinking and active planning. The concept paper, *Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda*, is expected to guide the discussion and provide initial recommendations for consideration by stakeholders. This document is available at **http://ideapolicy.org/pmp.htm.**

Thirteen regional focus groups were conducted to generate the final report. Throughout the focus group discussions, participants were explicitly asked for their recommendations for creating a shared agenda in Missouri, at both the state and local levels. These recommendations were subsequently compiled and offered for review at a final gathering of focus groups participants held at the University. As a result, recommendations for combating the barriers to a shared agenda emerged from several sources: the original focus group discussions, the final meeting of participants, University personnel responsible for conducting and analyzing the focus groups, and government officials from both DMH and DESE. These recommendations are as follows:

1. **Increase collaboration and support between mental health workers and school personnel.**
    1. Explore strategies for delivering mental health services in schools (e.g., policy and funding issues).
    2. Review current certification and licensing practices that might serve as barriers to offering mental health services in schools (e.g., recognition of the school counselor by Medicaid).
    3. Increase the awareness of the benefits of prevention and early intervention programs, such as Positive Behavior Support (PBS) and the Missouri School-Based Prevention, Intervention, and Resources Initiative (SPIRIT).
2. **Make mental health training a Priority.**
    1. This training should be strengths-based and focused on prevention, as opposed to a singular focus on mental illness.
    2. Although it is important to understand mental illness, the primary goal of training is to promote mental health in all children and youth.
    3. Provide pre-service and in-service competency-based training for teachers and others who work in schools. Make mental health training a requirement for teacher certification.
    4. Provide crisis intervention training in all schools.
    5. Integrate mental health awareness training into the classroom curriculum.
    6. Provide parent training to increase understanding and to “empower” parents whose children are affected by mental health problems.
    7. Provide mental health training to all new legislators.
    8. Provide mental health training to all new school board members.
    9. Provide training on school structure and practices to mental health personnel.
    10. Provide training on how to collaborate across systems.
    11. Establish a system of checks and balances to ensure that the above takes place.
3. **Make the prevention of mental illness a priority**.
    1. Promote mental health as a substantial component of the K-12 health curriculum for all children and youth.
    2. Increase resources for early identification of at-risk children.
    3. Provide mental health information and support for early childhood educators and care providers.

4. **Empower and support families at all levels.**
    1. Promote and make possible more family involvement in policy groups and decision making at the state level.
    2. Provide additional funding for parents to attend conferences, workshops, and policy meetings.
    3. Emphasize parent and family respect in schools and mental health agencies.
    4. Ensure that all schools have information on parent advocacy and support groups (e.g., NAMI, MPACT, MOSPAN) to disseminate to families in need.
5. **Create a statewide system of care network for the implementation of a shared agenda process.**
    1. Utilize state and regional system of care teams as coordinating bodies.
    2. Create school-based system of care teams within each school district.
    3. Mental health information and support funnels from the state level, through regional levels, and then down to local levels.
    4. Create a "blueprint" for a shared agenda at the state level (with regional and local input) and disseminate to all school-based system of care teams.
    5. Use the system of care network to create a statewide protocol for services with the goal of improving accessibility to, and consistency of, mental health services across Missouri.
    6. Create a database of mental health services available in each region that can be accessed by any school or child-serving agency.
6. **Develop a statewide campaign to promote mental health awareness and reduce the stigma of mental illness.**
    1. Create public service ads for television and radio.
    2. Create a collaborative panel (or panels) of families, mental health professionals, and school professionals to make presentations on mental health issues at a variety of venues across the state.

The full report from the Shared Agenda Project is available at:
http://schoolmentalhealth.missouri.edu/focusgroup/recommendations.htm

Criterion 2: Mental Health System Data Epidemiology

Missouri's estimate of prevalence and definition is consistent with federal definition and methodologies. Based upon a 7% prevalence rate, we estimate that approximately 100,000 Missouri youth experience SED, however, not all of these youth seek services from the public sector. We expect a presentation rate of 49,777 children with SED seeking services. The number of children and youth who receive CPS-funded services has consistently increased in the past several years. The Division served 12,305 children and youth during FY 2003. Please refer to the Appendix B Table A "2001 Census Data and Prevalence Rates" and Appendix C,

Table B "Characteristics of Consumers Served" for more information. The current definition of a youth with SED is consistent with the Federal Definition of SED. SED is defined in Missouri as:

1. Children and youth under 18 years of age.
2. Children and youth exhibiting substantial impairments in their ability to function at a developmentally appropriate level due to the presence of a serious psychiatric disorder. They must exhibit substantial impairment in two or more of the following areas:
   - Self-care including their play and leisure activities;
   - Social relationships: ability to establish or maintain satisfactory relationships with peers and adults;
   - Self-direction: includes behavioral controls, decision making, judgment, and value systems;
   - Family life: ability to function in a family or the equivalent of a family(for a child, birth through six years, consider behavior regulation and physiological, sensory, attention, motor or affective processing and an ability to organize a developmentally appropriate or emotionally positive state);
   - Learning ability;
   - Self-expression: ability to communicate effectively with others.
3. Children and youth who have a serious psychiatric disorder as defined in axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). An "exclusive" diagnosis of V Code, conduct disorder, mental retardation, developmental disorder, or substance abuse as determined by a DMH-CPS provider does not qualify as a serious emotional disturbance. Children from birth through three years may qualify with an Axis I or Axis II diagnosis as defined in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC-3).
4. Children and youth whose inability to function, as described, require mental health intervention. Further, judgment of a qualified mental health professional should indicate that treatment has been or will be required for longer than six months.
5. Children and youth who are in need of two or more State and/or community agencies or services to address the youth's serious psychiatric disorder and improve their overall functioning.

Serious emotional disturbance occurs more predictably in the presence of certain risk factors. These factors include family history of mental illness, physical or sexual abuse or neglect, alcohol or other substance abuse and multiple out of home placements. While these risk factors are not classified as specific criteria in the definition of serious emotional disturbance, they should be considered influential factors.

Criterion 3: Children's Services

Efforts continue on the development of a **comprehensive system of care** for children and youth. A system of care is a comprehensive array of mental health and other necessary services which are organized in a coordinated way to meet the multiple and changing needs of children, youth and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. The common philosophy of child-centered, family-focused and community-based services permeates the entire process. Partnerships between families, providers, communities, regions and the State are fundamental to an effective system of care.

The current climate regarding children's mental health issues suggests that this is an optimal time to implement a statewide system of care initiative. A landmark piece of legislation was passed during the 2004 legislative session**.** SB 1003 formalizes a children's comprehensive mental health plan that offers families access to mental health care without relinquishing custody of their child. The legislative initiative builds upon Missouri's system of care teams and SAMSHA Cooperative Agreement sites, as well as the 503 Project.

For more than ten years, the DMH, its advocates, family advocates, and providers have worked together to develop **local systems of care**. These efforts have often taken different forms but are based on the process of interagency staffing and collaboration and adhere to the common philosophy mentioned previously. The DMH is in the process of building upon and expanding these current efforts within all three of its Divisions. The strength of systems of care is not necessarily new funding or services, but is in the provision of better coordination of services. The DMH is working towards integration of services across Divisions as well as across State child serving agencies for those consumers with the most severe mental health needs including children with dual diagnoses. Consequently, a new position was created within the department. The Clinical Director for Children, Youth and Families was created and filled to enhance clinical services for children with needs from multiple divisions.

A number of significant activities have occurred with system of care thus far including:

- Development of a Comprehensive Children's Mental Health Management Team whose functions include oversight, coordination, and technical assistance to ensure implementation of a comprehensive children's mental health system. This committee consists of representatives from: The Department of Social Services; Children's Division, Division of Youth Services and Division of Medical Services, The DESE; Division of Vocational Rehabilitation and Division of Special Education, The Department of Public Safety, The DMH; Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities, The Office of State Court Administrators, Juvenile Court, and parents and parent advocacy groups and representatives from each of the geographic local systems of care. This group meets at least once a month.

- Development and implementation of a quality service review process for assessing the level of success of children living in their communities who are served by the local system of care groups.
- The DMH has been awarded two six-year federal grants from the SAMHSA to support system of care development through creation of an integrated interagency community-based system of care for children with severe emotional disturbance and their families. One grant serves six rural southwest counties: Greene, Christian, Taney, Stone, Barry and Lawrence and the other serves the St. Louis area. Local project development for the southwest counties is managed through partnerships with two Department of Mental Health Administrative Agents: Burrell Behavioral Health and the Clark Center and the St. Louis project is managed by BJC Behavioral Health Community Services and Hopewell Center. Lessons learned through these projects will be infused into Missouri's comprehensive children's mental health system.

Programmatic and systemic factors may contribute to "seamlessly" assisting **youth in transitioning into adulthood**. Traditionally, programs that offer services to children and youth with SED have done so in a highly categorical fashion. Systemic factors include the lack of coordinated services among the mental health, child welfare, education, juvenile justice and rehabilitation systems; inconsistencies and rigidity of State, county and local bureaucracies; and complexities of funding mechanisms. This situation often leaves youths and families without the necessary supports and services to successfully and independently make the transition into community life and work.
The complex challenges of the transition process and the individualized needs of children and youth with SED led to the development of a work group. The purpose of this group was to make recommendations regarding: 1) the role of CPS in serving transitional youth; 2) a process for transition planning; and 3) improved integration of services for youth and families in the transition process. To meet this goal the following tasks were undertaken by the work group:

- Conduct a literature review of "best practice" models implemented in other states;
- Review current Missouri practice regarding service delivery to transitional youth;
- Recommend practice elements to be included in a Missouri model of care for transitional youth;
- Identify the issues (barriers) related to the provision of services to transitional youth;
- Provide cross-training from each State agency partner regarding services and supports for the transitional youth population.

After finishing these tasks the work group issued "Best Practice" guidelines to provide guidance to clinical staff working with transitional youth. Additionally, members of the work group visited two exemplary programs in the state to gather further information on how successful programs are operating. The information gathered will be used to facilitate practice enhancements.

The DMH is involved in extensive activities regarding children, youth and families.
Each of the three divisions provides/purchases service and supports for children, youth and families, as well as participating in interdepartmental work that address a wide

variety of issues. While each division will maintain its primary focus in service delivery for children, youth and families, the department is committed to a departmental system. Therefore, activities, policies, and service development include system of care development. They are coordinated within the department under the direction of the Department of Mental Health Deputy Director. This better assures easy access and coordinated care for children, youth and families served by the Department and provides consistency in standard setting and interagency work.

Criterion 4: Targeted Services to Rural and Homeless Populations

The Missouri Association for Social Welfare (MASW) was awarded a contract in 2001 the by Missouri Housing Development Commission to conduct a census of homeless shelters. (The survey conducted was a point-in-time count.) The census data will be used by the Missouri Department of Economic Development as part of its Consolidated Plan to the US Department of Housing and Urban Development. (This is the fifth census in a series conducted by MASW.) The report shows 16,425 people being sheltered per day, an increase of 42% since the 1998 census. The sheltered homeless constitute a minority of homeless people. Numbers for the total homeless population (that is, including people living on the streets and places not designed for human habitation, people living in homeless shelters and people who are doubled-up living arrangements with family and friends because they no longer have their own homes) were derived by applying an annualizing factor developed by Dr. Renee' Jahiel, New School of Social Work, New York, and the relative percentages of sheltered to unsheltered and hidden homeless populations in a national study by Dr. Bruce Link & Associates, Columbia University and Dr. Martha Burt, Urban Institute, Washington D.C. This methodology results in 45,700 homeless persons per day and 87,250 homeless persons per year. According to the 2000 Homeless Children and Youth Census Report conducted by the Missouri Department of Elementary and Secondary Education, there are approximately 23,000 children and youth that are homeless ranging from age 0-21 years.

Criterion 5: Management Systems

Missouri's **strategic planning process** is based on the *Managing for Results Initiative*. A management tool for the Governor and his cabinet to help keep government focused on results and to drive meaningful improvements for citizens. This effort encourages fact-based decision making and innovation and recognizes the need for agencies to work together to drive significant improvements. The *Missouri Strategic Planning Model and Guidelines* was developed by the Interagency Planning Council to foster and assist State agencies in the use of a common strategic planning model that includes shared terminology and action calendars. These guidelines provide an outline for Missouri's planning principles and written plan components. The planning model provides measurement tools for evaluation of State government performance.

The current plan, October 1, 2002-developed for the FY 2005 budget cycle, reflects our continuing commitment *to address suicide in Missouri, particularly among the elderly and youth; to sustain efforts focusing on systems of care for Missouri's youth; to reduce deaths and injuries associated with substance abuse; and to continue quality of life initiatives aimed at mental health clients residing and receiving services in the community through effective recruitment and retention of a well-trained workforce, expanding comprehensive psychosocial rehabilitation programs, and increasing opportunities for meaningful employment of consumers*. Preliminary work on planning for the FY 2006 budget cycle is currently underway, but will essentially reflect an ongoing commitment to these same objectives.

Community mental health centers have discretion to use block grant funds for services describing the DMH-CPS Purchase of Service (POS) Catalog "Definition of Services Purchasable by Division of Comprehensive Psychiatric Services". The majority of services are delivered through contractual partnerships with the 25 community mental health centers in the State. The mental health centers employ staff as per the "eligible provider" outlined for each service in the catalog.

The following programs and projects have been implemented to increase the effectiveness of services:

- A joint training effort between the Division, the National GAINS Center and the Office of State Courts Administrator exploring issues of providing treatment and services to juveniles who have co-occurring diagnoses for drug addiction and mental illness and who have experienced the Juvenile Justice System. The training for staff, family members and advocates is designed so attendees will be able to go into each area of the State and train provider staff.
- Developing a consumer education program providing education structure, support group, and outreach services.
- Providing comprehensive mental health training services to the law enforcement community including characteristics of mental illness, coping with cultural and age diversity, and understanding medications and side effects.
- Training case managers, community support workers, substance abuse counselors, psychiatric aides and social workers to be better educated on diagnosing, treatment approaches, and working more effectively with individuals with mood disorders, personality disorders and obsessive compulsive disorders.
- Developing a more active role for consumers, families and community providers in the discharge planning process.
- Promoting the use of the more effective newer generation of psychotropic medication.
- Expanding eligibility criteria for the Comprehensive Psychiatric Rehabilitation Program so more individuals can participate in this Medicaid program.

FY 2005 State Plan
Adults

Criterion 1: Comprehensive Community-Based Mental Health System

The State's "Revised statutes of Missouri 2000" 630.020 set Departmental goals and duties. It says; "1. The Department shall seek to do the following for the citizens of this state:
(1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention;
(2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible;
(3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities or alcohol or drug abuse.
2. The department shall make necessary orders, policies and procedures for the government, administration, discipline and management of its facilities, programs and operations."
The **Community Psychiatric Rehabilitation Program (CPRP)** serves adults in their communities. Treatment planning is done with the consumer to maximize use of resources and individualize service provision.
Expansion of the Community Psychiatric Rehabilitation Program for both adults and children and youth has been a priority. The CPRP program is a client-centered approach that emphasizes individual choices and needs; features flexible community-based services and supports; uses existing community resources and natural support systems; and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. The program provides an array of key services including evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation. Program expansion since CPRPs inception brings us to the current consumer use:

Adults served in FY 04	26,326
Children and youth served in FY 04	4,155

(This count is determined by counting clients with a CPR service billed to either Medicaid or POS in FY04).

Because CPRP is a Medicaid supported program under the rehabilitation option, the federal government pays approximately 60 percent of the costs for clients with Medicaid eligibility. In 2001, the DMH promulgated "core rules" that provide common standards across the Divisions of CPS and ADA, where possible. These are also supplemented by specialized standards unique to the population served. Subsequently, in State FY 2003 a committee of provider and consumer representatives met and developed draft recommendations to enhance the CPR program in several key areas, including the development of continuous treatment teams, increased physician involvement in service planning, and incorporating both substance abuse services and vocational supports more

fully into the program. The division has established a collaborative partnership between CPS and ADA provider organizations to improve access and referral of individuals with co-occurring disorders to services.

Missouri received a State Incentive Grant for treatment of individuals with Co-Occurring Substance Related and Mental Disorders (COSIG) in the fall of 2003. Provider pairs for the pilot project have been identified in both rural and urban areas. As the work of the grant moves forward, providers are preparing to assess consumers as they usually would, screen for co-occurring disorders and make appropriate treatment decisions and referrals based on the assessment and screening findings. COSIG sites are in the process of hiring or identifying qualified staff members to work with individuals identified as having co-occurring disorders. CPR programs not identified as COSIG providers will be enhancing service delivery with an expanded array of services to include group and individual counseling at their own pace over the next year.

The Division of CPS continues to move forward with a **recovery-based care** model and has funded contracts for the development of consumer-run services ranging from **warm-lines to drop-in centers** for the past four years. Four contracts are currently in place for peer phone support services (warm-lines) in various sites throughout the state. Each warm-line is operated by mental health consumers. These services are intended to reduce feelings of social isolation and loneliness. The consumers answering the phone lines do not provide crisis intervention services but are trained to provide support, friendship and assistance over the telephone to other mental health consumers. Additionally, seven contracts are in place for consumer-run drop-in centers in a variety of settings statewide. These drop-in centers offer services such as, self-care education, support groups, peer-support, community integration activities, socialization skills education and recreational opportunities. The centers operate at a minimum of three days per week. Center staff members are primary mental health consumers who complete training sessions that pertain to the programs and initiatives of that particular center. The DMH has developed a formal monitoring process for consumer operated services to assure quality services and has applied the process during the last fiscal year.
In addition, the **Community Support Assistant Training and Certification Program** has been implemented. The goal of this program is to place mental health consumers into Community Support Assistant (CSA) positions after completing the training and certification program. The Division is currently in the process of developing a revised core curriculum that the CSA will complete prior to working with consumers. Continuing education will be spread over the next six months to two years. The Division has funded CSA positions and there are currently 11 positions filled with consumers who have completed the training program and continue to work.
Other services for adults that will continue to be provided, and enhanced when possible, are the following:

- **Targeted Case Management** includes the following services: arrangement, coordination, and assessment of the individual's need for psychiatric treatment and rehabilitation, as well as other medical, social, and educational services and supports; coordination and monitoring of services and support activities; and

documentation of all aspects of case management services, including case openings, assessments, plans, referrals, progress notes, contacts, rights and grievance procedures, discharge planning, and case closure.

- **Residential** – Residential services provide a variety of housing alternatives to meet the diverse needs of clients. Funds are used to support the cost of such housing services as nursing facilities, residential care facilities, group homes, and supported housing. Contractual arrangements are made to obtain these residential services in the community. As individuals move into more normalized housing alternatives, they require intensive and flexible services and supports in order to maintain that housing. Provisions of these services and supports will enable these individuals to successfully live and work in their communities.
- **Housing Options** – Within the past 2 years the DMH Housing Team has collaborated with community providers to develop semi-independent apartments through the HUD 811 process. This option targets those individuals who need additional supports in order to transition to independent living. During the current funding cycle, several CPS providers are submitting HUD applications to develop Safe Havens, low –demand housing for those with co-occurring mental illness and substance abuse disorders.
- Emergency services for consumers are provided through **Access Crisis Intervention (ACI)**. Service providers are trained by the Administrative Agents to respond to crisis calls. To ensure quality services that are delivered on a consistent basis the Division developed an administrative rule that governs the ACI program. ACI programs are certified to provide crisis services

Criterion 2: Mental Health System Data Epidemiology

Please refer to Appendix B, Table A "2001 Estimated Census Data and Prevalence Rates" and Appendix C, Table B "Characteristics of Clients Served" for complete information.

Definition of the Population
For the purposes of this plan, "adults suffering from severe, disabling mental illness" are defined as individuals, 18 years of age and older, who meet each of the following three criteria:

1) Disability: There must be clear evidence of serious impairment in each of the following areas of behavioral functioning.
   a) Social role functioning – ability to functionally sustain the role of worker, student or homemaker; and
   b) Daily living skills – ability to engage in personal care (grooming, personal hygiene, etc.) and community living activities (handling personal finances, using community resources, performing household chores, etc.) at an age-appropriate level.

2) Diagnosis: A primary diagnosis of one of the DSM-IV Diagnostic and Statistical Manual of Mental Disorders, (Fourth Edition, Revised in 1994) listed below, but such diagnosis may coexist with other DSM-IV diagnoses in Axis I or other areas.

a) Schizophrenic disorder (295.1,2,3,6 or 9)
b) Delusional (paranoid) disorder (297.10)
c) Schizoaffective disorder (295.7)
d) Bipolar disorder (296.4,5,6 or 7)
e) Atypical psychosis (298.90)
f) Major depression, recurrent (286.3)
g) Dementia or Other Organic Condition complicated with Delusional Disorder, Mood Disorder or Severe Personality Disorder (290.20, 290.21, 290.12, 290.13, 290.42, 290.43 or 294.10)
h) Obsessive-compulsive disorder (300.30)
i) Post-traumatic stress disorder (309.89)
j) Borderline personality disorder (309.83)
k) Dissociated identity disorder (300.14)
l) Generalized anxiety disorder (300.02)
m) Severe phobic disorder (300.21,22 or 23)

3) Duration: The individual exhibiting the disability specified in 1 (above) resulting from the DSM IV disorder specified in 2 (above) must meet at least one of the following criteria:
   a) Has undergone psychiatric treatment more intensive than outpatient care more than once in his/her lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).
   b) Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
   c) Has exhibited the disability specified in 1 (above) for a period of no less than a year.

Criterion 4: Targeted Services to Rural and Homeless Populations

The Missouri Association for Social Welfare (MASW) was awarded a contract in 2001 by Missouri Housing Development Commission to conduct a census of homeless shelters. (The survey conducted was a point-in-time count.) The census data is used by the Missouri Department of Economic Development as part of its Consolidated Plan to the US Department of Housing and Urban Development. The report shows 16,425 people being sheltered per day, an increase of 42% since the 1998 census. The sheltered homeless constitute a minority of homeless people. Numbers for the total homeless population (that is, including those people living on the streets and places not designed for human habitation, those people living in homeless shelters and those people who are doubled-up living arrangements with family and friends because they no longer have their own homes) were derived by applying an annualizing factor developed by Dr. Renee' Jahiel, New School of Social Work, New York, and the relative percentages of sheltered to unsheltered and hidden homeless populations in a national study by Dr. Bruce Link & Associates, Columbia University and Dr. Martha Burt, Urban Institute, Washington D.C. This methodology results in 45,700 homeless persons per day and 87,250 homeless persons per year.

The MASW homeless census report estimates that 28% of the homeless are those with severe mental illness, 34% are addicted to drugs or alcohol and 10% are both mentally ill and addicted. Thus, we estimate that on any given day in the State of Missouri 12,796 homeless individuals have severe mental illness, 15,538 are addicted to alcohol or drugs and that another 4,570 have a dual diagnosis. Annually there are about 24,430 homeless mentally ill, 29,665 homeless who are substance addicted and 8,725 dually diagnosed homeless individuals in the State.

About 60% of the homeless population in Missouri is concentrated in the metropolitan regions of the State, 25% are located in small cities and 15% in rural areas. A further breakdown of data indicates 39% are located in the Gateway/St. Louis region; 13% in the Lakes/Springfield region; 22% in the Mid-America/Kansas City region; 9% in the Central I-70 Corridor/Columbia region; 11% in the Southeast region/Cape Girardeau, Kennett, Popular Bluff, Sikeston; and 6% in the Northern Tier/Northwest Region. At this time reliable data is not available on the number of homeless individuals who are mentally ill and who are not receiving mental health services.

The Missouri Association for Social Welfare received a HUD grant in the 2001 Continuum of Care process to establish a balance of state Homeless Management Information System. (HMIS). Two years after receiving their HUD contract eighteen (18) of the forty-seven (47) projected agencies are participating in the HMIS. There is a plan to bridge with the other HMIS' in the state so that there is reliable data available by 2006 on the number of individuals that experience homelessness including those with mental illness and not receiving mental health services.

The following is a listing of programs and services available to assist persons with mental illness who are homeless:

- **PATH Grant** – This is a federal entitlement grant available to all states and territories to provide outreach and case management services to homeless individuals who are mentally ill and who may also have co-occurring substance abuse problems. PATH funds are used to continue services provided by the agencies originally funded through the Mental Health Services for the Homeless (MHSH) Block Grant. In 2001, a new provider was added in St. Louis and in 2002 a provider serving the rural Southeast area has been added with additional PATH funding.
- **Shelter Plus Care** is a program designed to link rental assistance tosupportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities. Currently DMH has twenty-one (21) Shelter Plus Care grants.. These grants provide rental assistance for over 1300 individuals and their families throughout forty different counties

expending over 6 million a year in rental assistance and 9 million in supportive services.

- **Access** – The Division of CPS received General Revenue funds to continue the outreach program initially started through the Access Demonstration Grant project, a five-year federal grant that recently expired.

Most of Missouri's geographic area is comprised of rural regions. Of the 25 service areas, 6 are designated as semi-rural and 10 are designated as rural according to the definitions based on the boundaries of Metropolitan Statistical Areas that have been adopted by CPS. It is estimated that 15% of Missouri's population live in rural areas with 25% concentrated in small towns and cities.. The special needs of rural and semi-rural areas are a challenge to all human services, especially in the areas of transportation, recruitment and retention of staff, and access and availability of services. Rural human services can be effectively addressed by interagency collaboration, involvement of local community leaders, and natural supports. Each of the 25 Administrative Agents are required to provide the key services that insure availability and access to mental health services. Some service areas have enhanced availability because independent Community Psychiatric Rehabilitation agencies are also established within their boundaries. All administrative agents that contract with CPS are required to have cooperative agreements with the State operated inpatient hospitals, and the primary CMHC has the responsibility of serving as the point of entry for anyone in that area receiving CPS services. Particular care is given to the screening of involuntary commitments to State facilities and coordination of services for consumers released from State facilities. Missouri is always challenged in its attempts to be equitable between rural and urban areas in the distribution of resources. Funding for community support services are distributed to provider agencies based on a set formula taking into account area population adjusted for the number of individuals at or below the poverty level.

Criterion 5: Management Systems

Missouri's **strategic planning process** is based on *Managing for Results*. The *Managing for Results* initiative is a management tool for the Governor and his cabinet to help keep government focused on results and to drive meaningful improvements for citizens. This effort encourages fact-based decision making and innovation the initiative also recognizes the need for agencies to work together to drive significant improvements. The *Missouri Strategic Planning Model and Guidelines* was developed by the Interagency Planning Council to foster and assist State agencies in the use of a common strategic planning model that includes shared terminology and action calendars. These guidelines provide an outline for Missouri's planning principles and written plan components. The planning model provides measurement tools for evaluation of State government performance.

CIMOR – Progress has been made in the development of a new information system. This system is the **Customer Information Management, Outcomes and Reporting (CIMOR) project**. Designed specifically as a tool for decision support, CIMOR will

enhance the ability to analyze cost of services delivered and to understand the impact of the level of service on outcomes. In summary, it will allow Department of Mental Health managers and stakeholders to clearly see how well the Department is meeting its commitment to garner and manage its resources, optimize its capacity to serve the people of Missouri and maximize the quality of the outcomes of the services it provides. To accomplish this, CIMOR subsystems, modules and special purpose databases will provide extensive automated support for managing enrollment, along with clinical, service, provider, and outcomes–related information. Built upon a unified data and transaction set in compliance with HIPAA and other government standards, CIMOR is based on leading edge technology. This will enable ready but highly secure access to information by those who need and are authorized to use it. In short, CIMOR represents not only a replacement of legacy systems but also a considerable addition to the Department's capacity to manage information on behalf of all of its constituents.

Since CIMOR is an information management and decision support tool, Department of Mental Health has elected to drive the development and deployment of the system through a common set of standards. The Department has adopted a proprietary decision support framework based upon a collection of nationally developed data, transaction, reporting, and outcome standards. CIMOR will support compliance with the requirements of the various regulators and accrediting agencies that monitor its performance. Using the Decision Support Framework, the CIMOR system will automatically capture management and clinical performance data from routine daily workflows that will: a) inform and support internal management decision-making and quality improvement; b) enable comparisons with national standards; and c) support required reporting and site visits of accrediting agencies.

Currently, the CIMOR system is anticipated to be operational in the beginning of FY06.

The Decision Support Framework builds upon the Mental Health Statistics Improvement Program's Decision Support 2000+ information infrastructure to extend it to support the MRDD and ADA domains, in addition to the Mental Health domain. A driving principle for CIMOR is that it must support sharing information across the Department of Mental Health system as part of its decision support feature.

The Department's leadership role is an important public mental health authority role that recognizes responsibility to populations in addition to target populations, including the general public, disaster survivors, and emergency responders. In the coming year, efforts will focus on revising the state's disaster mental health response plan to incorporate substance abuse response, training related to disaster mental health and cultural competence in disaster services, dissemination of a communication plan based on risk communication technologies, and continuing participation in statewide terrorism exercises, including large-scale regional exercises with the Strategic National Stockpile.

Additionally, the DMH received the HRSA 04 grant. This grant is being used to enhance the networking capacity and training of health care professionals to be able to recognize, treat and coordinate care related to the behavioral health consequences of bioterrorism or other public health emergencies. Other proposed activities under this grant include;

- To comply with minimal levels of readiness, DMH will complete an analysis of statewide behavioral health resources, current gaps in behavioral health services and anticipated needs.
- Integrate behavioral health components into hospital preparedness plans.
- Enhance the capacity for effective mental health response by providing information and training to health and mental health care workforces about mental health needs and effective responses in public health emergencies.

Strengths and weaknesses of the service system

The Division continues to move forward with training efforts for Community Support Assistants. Due to a reduction in funding for the past few years training has been sporadic and new CSA have not, as yet, been added to the original 11. The current plan is to revise and streamline training making it more cost effective while still providing consumer/employees with all of the information and skill training they will need to do their jobs. The CSA program is just one example of the Division's commitment to improving and expanding community services. The DMH is in the process of changing the manner in which it collects information about consumer satisfaction with its services. Focus groups being conducted now will help shape our new system for collecting and using consumer input. In this way the DMH will provide consumer driven services program wide as well as through individualized treatment planning.

Other systems established by the Department of Mental Health that strengthen the service system include: The **Office of Prevention** as part of a **Prevention Initiative**. The mission of this initiative is to enhance the health and well being of Missouri's children and youth, adults, and families through comprehensive approaches to reduce the incidence and prevalence of mental retardation and developmental disabilities; alcohol and drug abuse; and mental illness and serious emotional disturbances. The Department of Mental Health works to accomplish this mission by:

- Developing policies directed at changing community norms, attitudes, and laws
- Researching and deploying evidence-based preventive interventions to prevent the onset of disorders and disabilities
- Implementing continuous quality improvement strategies and outcome evaluations to ensure that interventions are timely, relevant, and effective
- Conducting staff development and training programs for agency and provider personnel on best practices

A risk and protective factor framework is employed to identify disorders and disabilities and preventive interventions. The initial activities under the Office of Prevention have included development and submittal of a youth violence prevention grant application and development of a proposal concept for preventive interventions with the children of substance abusing mothers. Suicide prevention activities are associated with both the

Division of Comprehensive Psychiatric Services and the Office of Prevention. Prevention programming addressing developmental disabilities is anticipated in the coming year.

In order to provide ongoing, open review of quality assurance and quality improvement processes, the Department of Mental Health created a **Council on Quality Improvement** in FY'03. The Council on Quality Improvement reviews the Department's quality assurance, quality improvement, and grievance/appeals processes to a) assure that the Department is appropriately exercising its responsibility to monitor and improve quality and to protect consumer rights; and b) advise the Department on how it can improve its tools and processes for evaluating quality and protecting consumer rights. The membership of the Council consists of a Mental Health Commissioner, the Director of the DMH Office of Quality Management, representatives recommended by the State Advisory Councils to reflect ADA, MRDD, and CPS constituencies (three consumers, three family members, and three community providers), one representative from the Missouri Protection and Advocacy program and a leadership representative from each of the three Divisions. Also under consideration is the creation of a Quality subcommittee of the Mental Health Commission. This subcommittee would review and recommend Department of Mental Health quality improvement initiatives.

The Council on Quality Improvement is involved in the following activities:

- Establish and maintain comprehensive knowledge of the various methods, processes and tools used for measuring, evaluating and reporting the quality of services and the protection of client rights within the Department of Mental Health span of control or influence
- Advise the Department on how to improve the methods, processes and tools used to evaluate, report and track quality and client rights issues
- Review sample reports from surveys, investigation and audits and offer critique and suggestions related to the methods used to construct and develop these reports
- Review quality and client rights summaries and trending information; develop and present improvement recommendations to the Department of Mental Health Executive Team and the Mental Health Commission
- Identify and forward to the council and Department, concerns and issues related to quality arising from their respective constituents

The Council on Quality Improvement met quarterly throughout FY'03 and FY'04. Agenda topics included the following: Reaffirming Department of Mental Health Value Statements, Reporting of Consumers Deaths, Medication Error/Injury Study of Consumers in Placement, Consumer Grievance Process, Assuring Quality in Habilitation Centers, Measuring Movement Towards Recovery for Persons with SMI, Role of Missouri Protection and Advocacy, ADA Performance Measures, Consumer Satisfaction Reporting, ADA High User Study, CPS Performance Measures; MRDD Performance Measures; Children's System of Care Quality Review Process; DMH Licensure; New ADA/CPS Certification and Monitoring Proposal; DMH Administrative Hearings Process.

Funding cuts over the past three years have caused the Department of Mental Health to restructure some services. One area to have significant changes deals with services to individuals who are deaf who need mental health services. Budget cuts resulted in a decrease in staff members for the past two years. A partial funding restoration in FY05 replaces 4 FTE interpreters for deaf services.

Analysis of unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them

Continuing in 2004, the Capacity Development committee comprised of Department of Mental Health staff, providers and consumers/family members, identified growth and development needs related to areas of the service array. The needs arose due to resource limitations and historical under-funding. However, among the areas that appear to be in especially short supply are housing subsidies and supports, acute care beds, community-based crisis alternatives to hospitalization, specialized treatment options for long-term services to adults and children and youth with challenging behaviors and symptoms, and mental health services for youth in the juvenile justice system. During periods of funding constraints, these gaps will be experienced as a result of high demand and over-utilization of scarce inpatient services.

The Capacity Development committee undertook its work by scanning the other states for methodologies to identify capacity needs for mental health service needs. For children's services, Friedman and Pires have established and promoted models for sizing components of care and the committee utilized their models to project capacity targets for Missouri's children. However, there is no generally accepted standard or model for sizing adult services. Although some states have used computer simulation technology, the cost of such an effort was prohibitive and the committee pursued an expert consensus panel of Missouri providers, consumers and policy-makers to project capacity using a process similar to that devised by Friedman. A review of literature and comparison to other states' experiences regarding need for services was conducted and Ciarlo census-based epidemiological figures were used to project need in the adult system. These projections are being compared to existing capacity to identify gaps in service delivery.

A statement of Missouri's priorities and plans to address unmet needs

Priorities include:

- continuing development of systems and services to help youth transition to the adult service system;
- decentralization of Supported Community Living, so that individuals are served in their community by local service providers who are trained and knowledgeable;
- development of a plan to to serve aging individuals with mental health problems;
- retaining and training committed caring staff who provide direct care services.

Priorities are being addressed through continued development of a comprehensive system of care for children and youth in Missouri. Transitioning youth are assisted with application for services in adult service settings and given services while a diagnosis is formulated. The Departments' system of care also recognizes the need to:

- Employs a diverse, culturally and linguistically competent workforce. (See Appendix D)
- Provides pre-service and in-service training and professional development activities for all staff and governing board members to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence (including families, youth, and peer professionals, etc.);
- Provides orientation training, mentoring, and other supports for all volunteers to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence; and
- Incorporates areas of awareness, knowledge, and skills in cultural and linguistic competence into position descriptions and performance evaluations for all staff.

A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

The President's New Freedom Commission on Mental Health's final report "Achieving the Promise: Transforming Mental Health Care in America" recommends that states address and monitor racial and ethnic disparities in access, availability, quality, and outcomes of mental health services as part of their comprehensive state mental health plans. Our state level strategic efforts include the following:

- Perform both need and asset assessments with the culturally and linguistically diverse groups in the service area.

- Develop and administer policy in partnership with families, youth and/or primary consumers.

- Design services and supports to meet the needs of culturally and linguistically diverse groups (e.g., family driven and community-based; flexible times, service hours, or appointments; language access services; culturally-based advocacy; use of cultural brokers, traditional healers, culture-specific assessments, interventions and treatment; and participatory action research).

- Use appropriate strategies to address barriers to the design and delivery of interventions, services, and supports (e.g., staff attitude and manner, service hours, service location, language, insurance, lack of awareness about systems of care principles and practices including failure to consider family, lack of knowledge about diverse cultural groups, fear and distrust of the service system, stigma associated with social-emotional and behavioral disorders or mental illness).

- Collect and analyzes data according to different cultural groups (e.g., race, ethnicity, tribal/clan affiliation, language, age, gender, sexual orientation, geographic locale, religion, immigration/refugee status, socioeconomic status, literacy levels, and other factors affecting mental health status of communities such as and violence, trauma).

- Evaluate and monitor the quality of interventions, services, and supports (e.g., through use of family and youth satisfaction surveys, focus groups, comparative analysis, policy teams that include families and youth). (See Appendix D)

Missouri continues to move forward with administrative restructuring. Decentralization of Supported Community Living Programs is underway, giving the community programs the ability to provide direct services to consumers with training, support and oversight provided by the DMH.
Hospital systems were formed in FY 2003 and during 2004 these districts concentrated on developing infrastructure supporting their consolidation. Currently the systems are developing processes for coordination with community providers on an administrative/planning level as well as a service level. In FY 2005 the thrust will be coordination of care with community providers. PROCOVERY, explained here, will be the service model used to move the system forward. PROCOVERY is an approach (developed by Kathleen Crowley) to healing based on hope grounded in practical everyday steps that individuals can take to move forward. PROCOVERY gives all caregivers a framework to do what superior caregivers do intuitively. PROCOVERY brings together three groups of people who are often at odds with one another --- consumers, family members and staff. PROCOVERY is a clear, unwavering belief in the possibilities of overcoming illness with a clear implemental framework of practical strategies and actions. There are 8 principles which include a focus forward and not backward; focus on life not illness; an individual can "just start anywhere"; and, keeping hope alive. To support the principles, there are 12 identified strategies which include gathering, utilizing and maximizing support; taking practical partnering steps; managing medication collaboratively; and sticking with procovery during crises and using those times to initiate procovery. Missouri DMH will be consulting with Kathleen Crowley throughout the next year developing 2 demonstration sites (urban and rural). Ms. Crowley's organization, Health Action, Inc., will be providing training seminars for consumers, family members and staff. We will also enlist Ms. Crowley to provide "Hope" seminars for DMH staff to ground us in the PROCOVERY philosophy. Our goal is to have a training track at the 2005 Spring Training Institute.

A brief description of the comprehensive community-based public mental health system that Missouri envisions for the future.

The Department of Mental Health is working towards a system that connects community based consumer driven services to the hospital systems serving the community. The future of the mental health system will have the community services surrounding the hospital systems. Consumers will enter the hospital system for acute care or long term care through the Administrative Agents. Discharge planning to

ensure care coordination and success will occur prior to re-entry into the community. Care coordination teams will work on behalf of the client to facilitate successful community tenure. This vision of the future embraces the Department of Mental Health's stated values of; access to services, individualized services and supports, and quality services through monitoring, staff training and ongoing technical assistance.

Coupled with this effort is a plan to develop satisfaction surveys that will inform and guide the Division in the delivery of community based services. At present, a consulting firm is conducting focus groups across the state, designed to poll consumers, family members, stake holders and other community members concerning their thoughts, feelings and perceptions of the mental health service system. These focus groups will inform the DMH concerning services needs and gaps in services. Following the focus groups a new system to collect data concerning satisfaction with services and service sites will be developed. In coming years, the DMH will add a service satisfaction performance indicator and other system level performance indicators to the Mental Health Block Grant Section III under Criterion 1 for both adult and children and youth community-based services.